

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05082

## CERTIFICATE OF DEATH

05081

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY  Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ridgely		c. LENGTH OF STAY IN 1b 20 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		d. STREET ADDRESS None	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Adam	Middle Stayer	Last Holsinger
4. DATE OF DEATH	Month 4	Day 14	Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 31, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Penns.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David P. Holsinger		14. MOTHER'S MAIDEN NAME Amelia Stayer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT Russell Holsinger Ridgely, Md.	
Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  H221		Renal Insufficiency	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b) Arteriosclerotic C.V.Disease	
		DUE TO (c) Generalized Arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  Cancer of the Prostate with regional metastasis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 5, 1965, to Apr. 14, 1966, that (I) (we) last saw the deceased alive on Apr. 14, 1966, and that death occurred at M, from the causes and on the date stated above.		22b. DATE SIGNED Apr. 15 '66	
22a. SIGNATURE  Charles H. Stonesifer		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Charles H. Stonesifer, M.D. Greensboro, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-16-66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Greensboro		23d. LOCATION (City, town or county) (State) Greensboro, Maryland	
24. FUNERAL DIRECTOR J. E. Bocelaire Greensboro, Md.		25a. REC'D BY REGISTRAR APR 22 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

1921-1922

1922-1923

1923-1924

1924-1925

1925-1926

1926-1927

1927-1928

1928-1929 1929-1930 1930-1931 1931-1932 1932-1933

1933-1934 1934-1935 1935-1936 1936-1937 1937-1938

1938-1939 1939-1940 1940-1941 1941-1942 1942-1943

1943-1944

1944-1945 1945-1946

1946-1947 1947-1948

1948-1949 1949-1950 1950-1951 1951-1952

1952-1953

1953-1954

1954-1955 1955-1956 1956-1957 1957-1958

1958-1959 1959-1960

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 7 Film G376 5/16/66 mh

05083

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05082

1. PLACE OF DEATH a. COUNTY <b>CAROLINE</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Rural Preston</b>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Rural Preston</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>(None)</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)		First <b>HARVEY</b>	Middle	Lost <b>HOPKINS</b>	4. DATE OF DEATH Month <b>4</b>	Day <b>20</b>	Year <b>1966</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED WIDOWED <input type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/> <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 19, 1902</b>	9. AGE (In years lost birthday) <b>63 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mrs. Andrew Kelley</b>		Address <b>Preston, Md</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b>		DUE TO (b) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH minutes			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <b>Generalized arteriosclerosis</b>		DUE TO (c) <b>Generalized arteriosclerosis</b>		<b>15 yrs</b>			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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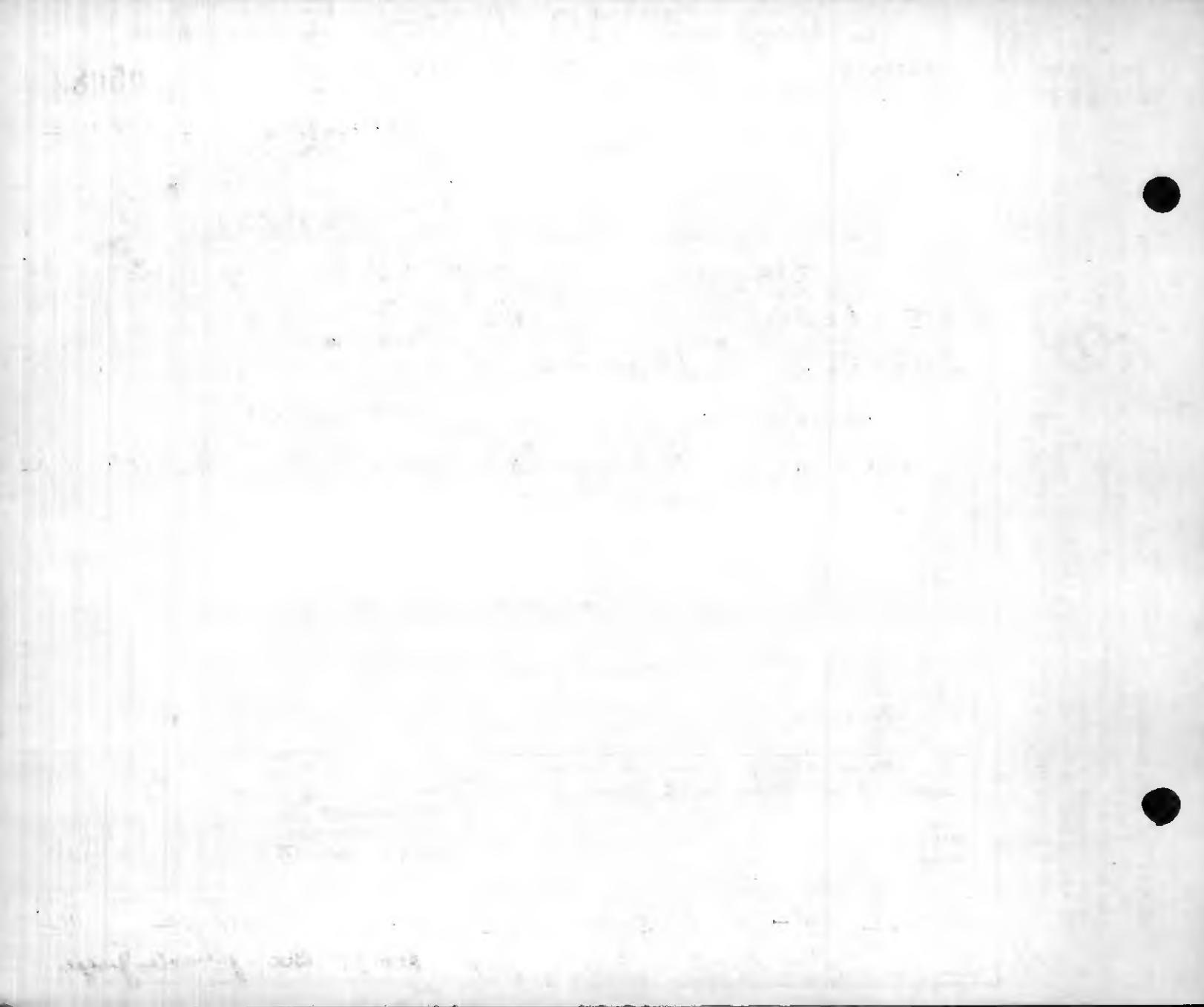
20a. INJURY WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>and mental retardation</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>4/27.66</b>	
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ACTUAL SIGNATURE <b>Harold B. Plummer M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23b. DATE THEREOF <b>4-22-66</b>		Address (Street, city, town, or county) <b>CAROLINE MD</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>BETHLEHEM CEMETERY</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR ADDRESS <b>James B. Flashell Easton, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 28 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 4 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05084

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05083

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>106 South University Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Ralph (Jim) Eugene</b>	Middle <b>Howard</b>	Last 4. DATE OF DEATH <b>April 1 1966</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>April 30, 1927</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plant Superintendent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Poultry Processing</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Cambridge, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME <b>Jerome Howard</b>		14. MOTHER'S MAIDEN NAME <b>Anna Fisher Wother</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>218-20-8249</b>	
17. INFORMANT <b>Mrs. Kathleen W. Howard, Federalsburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Myocardial infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b>	
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		DUE TO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4-7-66</b> , 19, to <b>4-7-66</b> , 19, that (I) (we) last saw the deceased alive on <b>4-7-66</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.		22b. DATE SIGNED <b>4-9-66</b>	
22c. SIGNATURE <b>Frank M. Anderson</b>		22d. ADDRESS <b>Federalsburg, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 9, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Hill Crest Cemetery</b>
24. FUNERAL DIRECTOR <b>J. J. Fyampton and Son, Federalsburg, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 14 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

actions

harmful

actions

undesirable

desire

undesirable

actions, undesirable, 201

actions, undesirable, 201

as

thus

harmful

actions (also, 201)

as 201, as thus

as 201, as

actions, undesirable, 201, actions, undesirable, 201, actions, undesirable, 201

actions, undesirable, 201

actions, undesirable, 201

actions, undesirable, 201, actions, undesirable, 201, 202-203

actions, 201

actions, undesirable, 201

*Frank M. Dyer*

actions, undesirable

actions, 202, 203, 202-203, 203

actions, undesirable, 202, 203, 203

1 M  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05085

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05084

1. PLACE OF DEATH  
a. COUNTY

Caroline

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Ridgeley

c. LENGTH OF STAY IN 1b

79 Yrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

None

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

b. STATE

Maryland

b. COUNTY

Caroline

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Ridgeley

05-1

d. STREET ADDRESS

None

e. IS RESIDENCE  
ON A FARM?

YES  NO

3. NAME OF  
DECEASED  
(Type or print)

First  
Elma

Middle  
Thomas

Last  
Price

4. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

10. Months

11. Days

12. Hours

13. MIN.

Female

Col.

WIDOWED

DIVORCED

10-8-1886

79 yrs.

12. CITIZEN OF WHAT  
COUNTRY?

U.S.A.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR  
INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Maryland

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Henry Price

No Record

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

220-01-7583

Henry Price Ridgeley, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

INTERVAL BETWEEN  
ONSET AND DEATH  
3 hours

442X  
DUE TO  
(b) Chronic Congestive Heart Failure

4-5 yrs

DUE TO

(c) Atherosclerosis Cardiac Renal Disease

10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m. 19

20d. INJURY OCCURRED  
White at work  Not White at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion  
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

Harold B. Plummer M.D.

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

22. DATE SIGNED

4/14/65

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORI

23d. LOCATION (City, town or county) (State)

Burial

4-12-66

Thomas Burial Ground

Ridgeley, Maryland

24. FUNERAL DIRECTOR

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

J. E. Boulaire Greenlawn, Md.

DATE

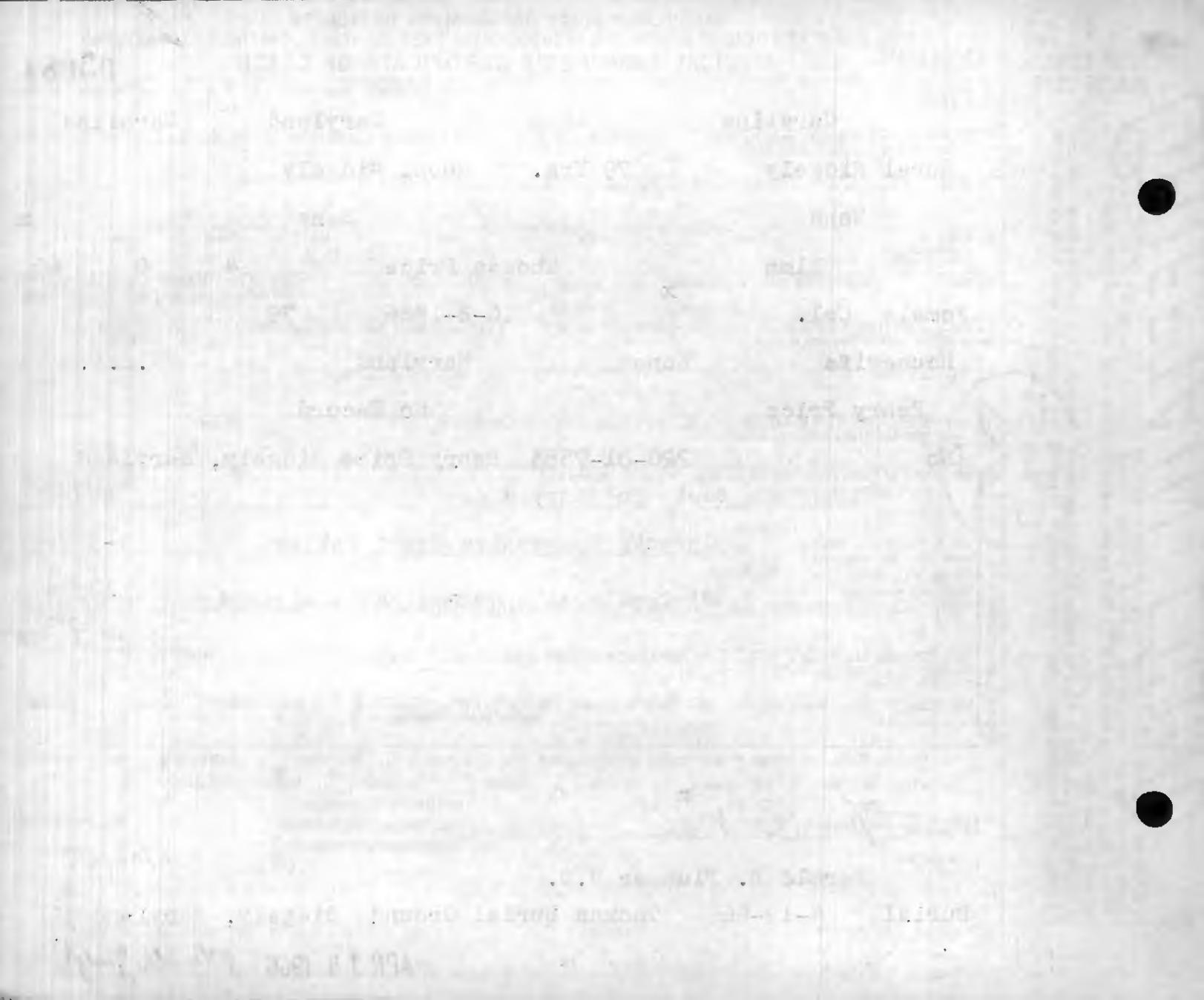
APR 18 1966

Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

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FOR STATE  
HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston - Rural</b>				c. LENGTH OF STAY IN 1b <b>6 years</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston - Rural</b>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Preston - Harmony Road</b>				d. STREET ADDRESS <b>R.F.D. #2</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Charles</b>			First <b>Charles</b>		Middle <b>Puff</b>		Last <b>Jr.</b>		4. DATE OF DEATH <b>April</b>		Month <b>28</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>October 21, 1895</b>		9. AGE (in years last birthday) <b>70</b> yrs.		10. UNDER 1 YEAR Months <b>0</b>		11. UNDER 24 HRS. Days <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Paymaster</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Woolen Mills</b>				11. BIRTHPLACE (State or foreign country) <b>Passaic, New Jersey</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Charles Puff</b>						14. MOTHER'S MAIDEN NAME <b>Margaret (maiden name unknown)</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>143-05-1151</b>				17. INFORMANT <b>Mrs. Emma Puff, Preston, Maryland, RFD</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Acute Coronary Occlusion</b> IMMEDIATE CAUSE (a) <b>4201</b> DUE TO (b) <b>Coronary sclerosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b>												INTERVAL BETWEEN ONSET AND DEATH minutes <b>107</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Pulmonary Emphysema and extrinsic asthma</b>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>While at work</b>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>p.m.</b> <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Wilmington, Delaware</b>				20f. (City or town) <b>Wilmington</b>		(County) <b>Delaware</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>Harold B. Plummer, M.D.</b>												22. DATE SIGNED <b>April 29, 1966</b>			
ACTUAL SIGNATURE 												CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Preston, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>				23b. DATE THEREOF <b>May 2, 1966</b>				23c. NAME OF CEMETERY OR CREMATORIAL <b>Silverbrook Crematory</b>				23d. LOCATION (City, town or county) <b>Wilmington, Delaware</b>			
24. FUNERAL DIRECTOR <b>J. J. Frampom and Son, Federalsburg, Maryland</b>				ADDRESS <b>From Frampom Jr.</b>				25a. REC'D BY REGISTRAR <b>MAY 3 1966</b>				25b. REGISTRAR'S SIGNATURE 			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05087

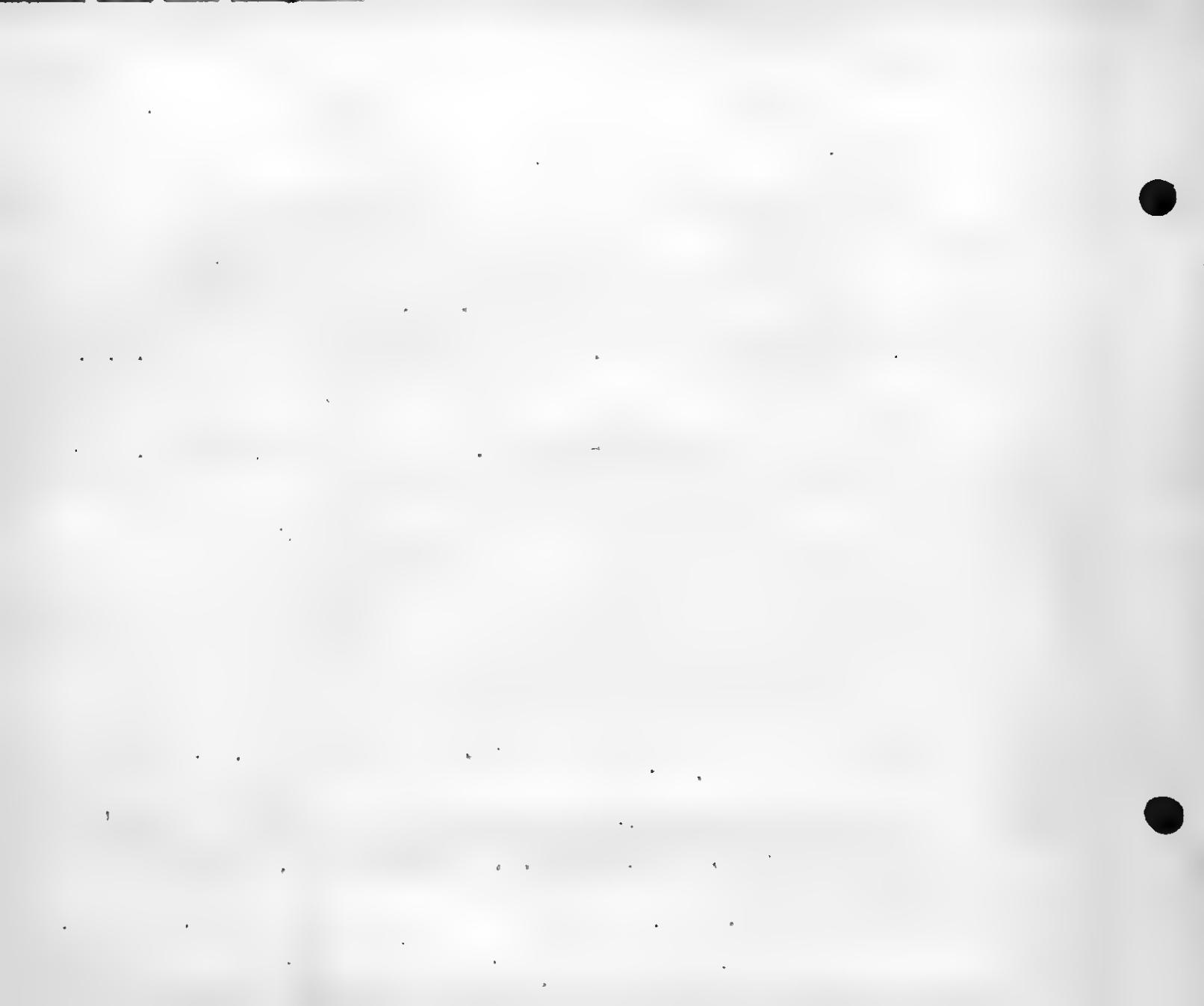
## CERTIFICATE OF DEATH

05086

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro		c. LENGTH OF STAY IN 1b 88 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Charles	Middle Ralph	Last Rich
4. DATE OF DEATH April 29	Month 1966	Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Oct. 19, 1877	9. AGE (In years last birthday) 88 yrs.	10. IF UNDER 1 YEAR Months Days Hours Minutes	11. IF UNDER 24 HRS Hours Minutes
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Geo A. Reach	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Rich		14. MOTHER'S MAIDEN NAME Margaret Turner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-01-4504 17. INFORMANT Mrs. Annie Rich Greensboro, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 45m DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Renal Insufficiency			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Feb. 19, 1966, to Apr. 29, 1966, that (I) (we) last saw the deceased alive on Apr. 29, 1966, and that death occurred at 215B, from the causes and on the date stated above.			
22a. SIGNATURE Charles H. Stonesifer		22b. DATE SIGNED May 2, 1966	
22c. PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.		22d. ADDRESS Greensboro, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 2, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Greensboro		23d. LOCATION (City, town or county) (State) Greensboro, Maryland	
24. FUNERAL DIRECTOR J. E. Bocelis Greensboro, Md.		25a. REC'D BY REGISTRAR MAY 5 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1  
NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05088

PLACE OF DEATH  
a. COUNTY

CAROLINE

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

RIDGELEY

c. LENGTH OF STAY IN 1D

2542d.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF  
DECEASED  
(Type or print)

FRANK THOMAS SCHMITT

4. DATE  
OF  
DEATH

APR. 13, 1966

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED

 NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

NOV 6, 1924

9. AGE (in years  
last birthday)

41

10. IF UNDER 1 YEAR  
Months Dey11. IF UNDER 24 HRS.  
Hours Min.10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

BUTTON CUTTER

10b. KIND OF BUSINESS OR INDUSTRY

PEARL BUTTON

11. BIRTHPLACE (County &amp; State, or foreign country)

MD

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

FRANK WILLIAM SCHMITT

14. MOTHER'S MAIDEN NAME

BLANCHE POLLARD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or grade of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

MRS. FRANK T. SCHMITT, RIDGELY, MD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)521K  
DUE TOConditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

Abscess of left lung

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

Malnutrition and Anemia

19. WAS AUTOPSY  
PERFORMED?YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year  
Hour e.m. 20d. INJURY OCCURRED  
p.m. 19 While at work  Not While at work 

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 10, 1965 to Apr. 13, 1966, that (I) (we) last saw the deceased alive on Apr. 13, 1966, and that death occurred at ..... M, from the causes and on the date stated above.

22a. SIGNATURE

Charles H. Stonesifer, M.D.

M.D.

ATTENDING PHYS.  MED. DIRECTOR  STAFF PHYS. Apr. 15 '66  
22b. DATE SIGNED

22d. ADDRESS

Greensboro, Md. 21639

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL (State)

Burial APR. 16, 1966

RIDGELEY

RIDGELEY

MD.

24. FUNERAL DIRECTOR'S SIGNATURE

Charles V. Moore Denton, Md.

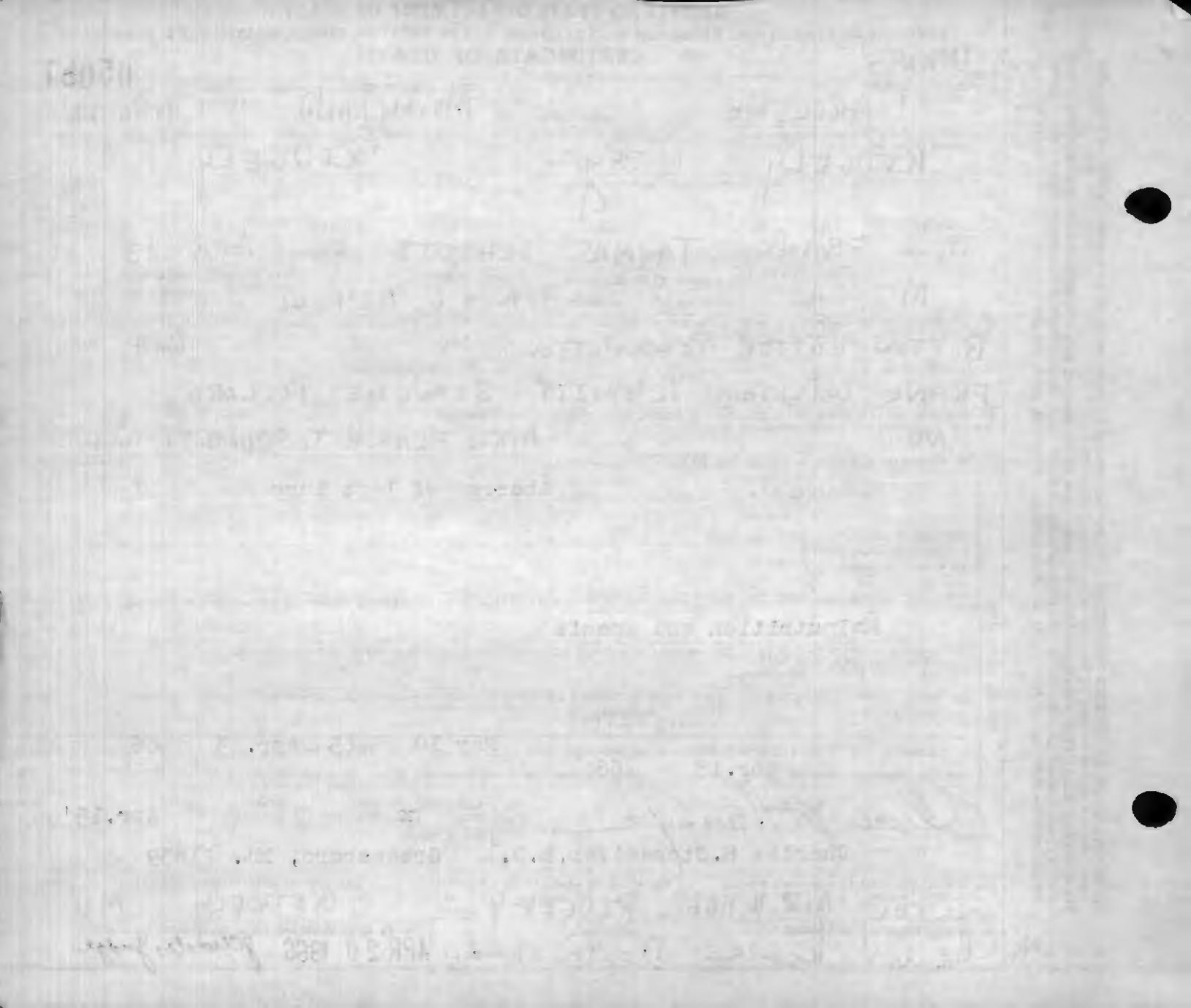
ADDRESS

REC'D BY REGISTRAR

APR 20 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**05089**

**CERTIFICATE OF DEATH**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE		Maryland b. COUNTY		Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Henderson		c. LENGTH OF STAY IN 1b 4 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Henderson		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None				None					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH		Month	Day	Year
Female		Anna Marie Vavrinec			April 15				1966
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Female		Cau.	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	May 22, 1875	90 yrs.	Months Days Hours Min.		Czechoslovakia	U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Housewife		None		14. MOTHER'S MAIDEN NAME			
13. FATHER'S NAME		James Cepek				Marie Kutilek			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		No		16. SOCIAL SECURITY NO.	17. INFORMANT		Address		
				220-46-0072	Margaret Snow		Henderson, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Failure INTERVAL BETWEEN ONSET AND DEATH									
443 X DUE TO Chronic Myocarditis									
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b)									
DUE TO Arteriosclerosis C.V. Dis. with (c) Hypertension									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? Parkinson's Disease YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
19									
21. I certify that (I) (this hospital) attended the deceased from Apr. 1, 1966, to Apr. 15, 1966, that (I) (we) last saw the deceased alive on Apr. 14, 1966, and that death occurred at M, from the causes and on the date stated above.									
22a. SIGNATURE Charles H. Stonesifer M.D.									
22b. DATE SIGNED 4/15/66									
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>			
		22d. ADDRESS Greensboro, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)	
Burial		April 19, 1966		Holy Redeemer		Baltimore		Md.	
24. FUNERAL DIRECTOR		ADDRESS							
John St. H. Stonesifer		3331 Belvoir St.							

